HEMOPHILIA ASSISTANCE PROGRAM
Texas Department of Health
Bureau of Kidney Health Care
1100 West 49th Street, Y-950
Austin, Texas 78756
(512) 834-4551, (800) 222-3986
Fax (512) 834-4561

APPLICATION FOR ASSISTANCE
(Adults over 21)

1. Applicant Information

Applicant's Name: (Last, First, Middle)	Home Telephone: ( ) Work Telephone: ( )		
Permanent Mailing Address: (Street, P.O. Box, RFD)			
City:	Zip:	County:	State:
Date of Birth: (month/day/year)	Place of Birth: State: County:		
**Social Security #:	Sex: Q Male Q Female		
Resident of Texas? Q Yes Q No			

** The SSN is needed to coordinate hospitalization and medical benefits between HAP and other third-party payers such as an insurance policy, individual health plan, group health plan.

2. Members of Household

Name	Date of Birth	Relationship to Patient

3. Income and Assets Information

Note: If patient/family is currently receiving Medicaid or Food Stamps, do not complete this section; go to Section 4.

A. The following information is **required** of the **patient and/or patient's spouse and/or any other person(s) legally obligated to provide for the patient**:

Name	Relationship to Patient	Employer Name and Address	Gross Annual Income

B. Other sources of income available to the family or patient: (check yes or no on each item)

Type of Income	No	Yes	If Yes, Amount Received Each Month
Dividends			
Royalties			
Pensions/Retirement			
Social Security			
Social Security Disability			
Social Security Survivors			
Social Security Benefits			
Unemployment Compensation			
Rental Property			
Deferred Income			
Disability Income			
Other: Please Specify			

C. Value of Assets of Patient or Legally Responsible Person(s):

1. Do you own your home Q Yes Q No

2. Do you own a farm? Q Yes Q No
   If yes, is this farm over 200 acres? Q Yes Q No

3. Do you own other real estate? Q Yes Q No
   If yes, current market value: $ _____

4. Savings/Money Market Accounts: $ _____

5. Cash value life insurance: $

6. Automobiles:

Make	Year of Model	Amount Owed ($)
1.		
2.		

4. Insurance Information on Patient

Is the patient insured: Q Yes Q No

If Yes, through whom? Q Patient Employer Q Spouse/Parent Employer Q Private Policy

Name of Insurance Company: _____

Address: _____ Telephone Number: _____

Policy Number: _____ Group Number: _____

Does insurance cover blood factor reimbursement? Q Yes Q No
If yes, what percentage does the insurance pay? _____

Effective Date: _____ Termination Date: _____

The law requires that if the patient has medical insurance coverage, it **MUST** be used prior to assistance provided from this program. Insurance coverage must be continued to maintain program eligibility. All medical insurance pertaining to the patient must be listed below.

5. Medicaid and Other Benefits

A. Is patient covered by Medicaid? Q Yes Q No If Yes, Medicaid #: _____

Check other benefits being received: Q AFDC Q Food Stamps Q Other

B. Is patient covered by Medicare? Q Yes Q No If Yes, Medicare #: _____

C. Is patient receiving benefits from other programs, fund-raising activities, special charities, gifts, and/or donations? If yes, please list: _____

6. Applicant's Statement

I understand that this application is a legal document and that by signing I am stating from my personal knowledge that the facts in the application are true and correct. I understand that the application will not be accepted if it is incomplete.

I authorize release of medical information to the Texas Department of Health as necessary to determine and maintain eligibility of the patient.

Signature of applicant/guardian: _____ Date: _____

7. Attach Verification Documents Here

Q Residency Verification – attach a copy of one of the following:
- ★ valid driver's license
- ★ rent or utility receipts for two months prior to the month of application
- ★ voter registration

Q Income/Assets Verification – attach a copy of one of the following
- ★ employer's written verification of gross monthly income
- ★ the most recent pay check stub/monthly employee earnings statement for two (2) months
- ★ Internal Revenue Service (IRS) Income Tax Return forms for the most recently completed year
- ★ pension/allotment award letters

PLEASE NOTE:

VERIFICATION OF TEXAS RESIDENCY AND INCOME INFORMATION MUST BE ATTACHED UNLESS THE PATIENT OR FAMILY IS CURRENTLY RECEIVING MEDICAID OR FOOD STAMPS.

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.tdh.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004.)

8. Medical Information

This section must be completed for all new applicants to the Hemophilia Assistance Program and with every change in treating physician.

After completion, this form must be signed by a Texas licensed physician **OR** a signed letter or medical report from a Texas licensed physician which contains the information may be substituted.

Name of Treating Physician:			
Address of Treating Physician:			
City:	State:		Zip:
Diagnosis:	Patient's Height:	Patient's Age:	Patient's Weight:

Q Hemophilia	Usually Treated in:	Number of vials/units and type of blood products used during the last 12 months:	
Q Hemophilia B	Q Clinic		
Q With Inhibitor	Q Emergency Room	Vials/Units	#
Q Without Inhibitor	Q Hospital	Type of Product	
Q Other	Q Home		

Where are blood products obtained?	
Average number of bleeding episodes during the last 12 months:	
Date of last episode:	
Joints involved:	
Brief statement of anticipated treatment needs in coming year.	

Signature of Physician:_____ Date:_____